Child and Adolescent Psychiatry Case Review

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Learning Objectives

- To develop a system for assessment and formulation of child and adolescent psychiatry cases using a case based module.
- To highlight differences between C/A vs adult presentation of mental illness.
- To be familiar with unique issues in child and adolescent behavioral health maintenance.

Case 1

- 13 yo male c/o poor sleep, irritability, increased energy, decreased appetite. +growth delay; declining grades in past 6 months but had been an “A” student. Mother noted poor self esteem, but plays with select friends and enjoys skateboarding. No other behavior problems.
- PMHX: SGA, normal vaginal birth, unremarkable perinatal history
- Q1: How will you proceed with the assessment?

Case 1: 13 yo boy with growth delay

- Bio:

- Obtain additional information regarding development, growth pattern, etc
- Speak with family, with patient individually, collateral info with consent
- Differential Diagnosis IAW age
- Complete Medical Work-up!

Presentation of Disorders

- Pre-school
  - ADHD
  - Oppositional Defiant Disorder
  - Developmental Disorders
  - Mental Retardation

School Age

- Depression
- Anxiety
- Learning Disorders
- Tic Disorders
- ADHD
- ODD

Presentation of Disorders

- Adolescents
  - Conduct Disorder
  - Substance Use Disorders
  - Mood Disorders: Depression, Bipolar
  - Anxiety Disorders
  - ADHD, ODD

Case 1: 13 yo boy with growth delay

- Psych/Social: Recognize age-appropriate epigenetic (Erikson) and cognitive (Piaget) stage.
- Erikson: stages of life are sequential, each stage relying on the next; if stage is not completed, unresolved issues continue to arise and cause problems in later stages
- Piaget's Model of Cognitive Development: continuous schema of stimulus-response-awareness

Erikson’s Epigenetic Model of Development

- Basic trust vs mistrust (birth-1)
- Autonomy vs Shame and doubt (1-3)
- Initiative vs Guilt (3-6)
- Industry vs Inferiority (6-12)
- Identity vs Role Confusion (12-20)
- Intimacy vs Isolation (20-40)
- Generativity vs Stagnation (40-65)
- Ego Integrity vs Despair (65+)

Piaget's Model of Cognitive Development

- Sensorimotor Stage (to 18-24 months)
- Pre-Operational Thought (2-6 yrs)
- Concrete Operations (7-11yrs)
- Formal Operations (12+ yrs)
  - abstract
  - deductive
  - conceptual

Freud's Psychosexual Model of Development

- Oral Phase (birth-1 yr): breast feeding is main focus, source of frustration and satisfaction
- Anal Phase (1-3 years): focus shifts to bowel function; control of body functions
- Phallic (3-5 years): genitals become focus; masturbation to release tension but leads to guilt and anxiety
- Latency (6-11 years)
- Adolescence (12-18 years)

Case 2

- 10 yo boy referred by school for behavior problems. Patient disciplined for stealing pencils. No developmental issues.
- ROS: insomnia, +vigilance, +anxiety, poor appetite, denied other depression, manic and thought do sxs. YBOCS+
- Q2: Differential Diagnosis?
- Q3: How will you address legal issues?

Disruptive Behavioral Disorders

- ADHD- hyperactive-impulsive and/or inattentive for >6 months.
- Oppositional Defiant Disorder- a pattern of negative, hostile, defiant behavior for at least 6 months, against authority figures.
- Conduct Disorder- basic rights or age appropriate societal norms/rules violated

Anxiety Disorders

- Separation Anxiety- excessive
- Obsessive Compulsive Disorder- contamination, self doubt/guilt
- PTSD
- Social Phobia- fear of embarrassment in social situations
- Generalized Anxiety Disorder- excessive worry >6 months; usually performance

Case 2: 10 year old boy stealing pencils

- Legal Issues: Breach limits of Confidentiality in setting of
  - child abuse
  - maltreatment
  - appropriate education (child custody)
  - suicidal or homicidal patient

Case 2: 10 year old boy stealing pencils

- PANDAS- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

Case 3

- 13 year old boy refuses to talk in school x3 months. +declining grades, poor sleep won't sleep in his room. + "shadow" friend that he talks to. On exam, patient has breast budding. Boy thinks he is a girl. He is tangential and has slowed cognition.
- Q4: Differential Diagnosis?
- Q5: Medications management?

Sexuality

- Sexual Identity- biological sexual characteristics (internal/external organs, genes, hormonal make-up, secondary characteristics)
- Sexual orientation- object of impulses
- Gender identity- sense of being male/female
- Sexual behavior-physiological experience

Communication Disorders

- Expressive Language D/O- limited vocabulary, word recall and production
- Mixed Receptive-Expressive Language D/O-impaired comprehension and expression.
- Phonological- errors in sound production
- Stuttering- disturbance in normal fluency

Selective Mutism

- Consistent failure to speak in specific situations despite speaking in others
- Occurs for at least 1 month and interferes w/achievement or social communication
- 90% met criteria for social phobia
- Speech abnormalities, delayed speech onset contribute, but etiology is psychological.

Mood Disorders

- Lead to accumulation of failures
- Irritability may be presenting symptom
- Fail to gain weight rather than weight changes
- In adolescents- delusions, anhedonia, psychomotor retardation.
- Somatic complaints, mood congruent AH

Psychotic Disorders

- Less complex hallucinations/delusions
- Developmental issues complicate diagnosis
- Unlike Autism, has normal intelligence and language, +Family Hx, sxs begin after 5 yo.
- Fail to meet expected levels of social and academic achievement rather than deterioration (adults).

Violence

- No unifying profiles for adolescent murderers; but most give warning
- School incidents- gang related, vengeance for teasing, romantic relationships
- Comorbid MDD, +social isolation, displayed fascination with firearms (experts)

Medications Management

- Treatment: atypical neuroleptics, antidepressants, mood stabilizers (?)

  - no FDA approved SSRIs, all are off label; note association with increased suicides

  - start low, go slow with any medication

  - Uncertain effects of long term medications use.

Case 4

- 15 year old female s/p Tylenol overdose after being hit by her father. +bruising. +Chaotic family environment. +Sexually active. Acetaminophen level >250 (4 hrs).
- Q6: Medical assessment and management?
- Q7: Disposition issues when medically stable?

Case 4: 15 year old s/p overdose

- Suicide:
  - commonly precipitated by family or relationship issues
  - increased frequency with age
  - girls attempt more than boys
  - #1 firearms, #2 hanging in boys
  - NOT always with Mood DO

Case 4: 15 year old s/p overdose

- Management:
  - SAFETY (involuntary vs voluntary)
  - Treat Tylenol overdose (NAC)
  - address other substance use (UDS, CAGE)
  - HCG, RPR, HIV (inquire about STDs and contraception)
  - info regarding prior suicide history

Abuse

- Increased in premature babies, families w/substance abuse, and multiple psychosocial stressors
- Physical-parental hx may not match injuries, guarded attitude, frequent ER visits
- Sexual-any sexual contact, prostitution, or pornography

Case 5: 15 year old s/p overdose

- Disposition issues
  - refer to FAP/CPS; CAPS
  - remove weapons/medications at home and minimize suicide risk
  - counseling for sex, drugs, alcohol
  - Crisis intervention plan

Case 6

- 8 year old boy is brought in by his mother. She claims he is recently diagnosed with mental retardation and requests more information.
- Q8: Contributing socio-cultural factors?
- Q9: Associated genetic conditions?
- Q10: Causes of MR?

Mental Retardation

- IQ < 70 AND impairment in adaptive functioning in 2 areas; before age 18
- Degree- Mild, Moderate, Severe, Profound
- Seizures are common
- Increased risk of psychopathology
- Causes- chromosomal, metabolic, toxins, CMV, Rubella

Case 6: Boy with MR

- Socio-Cultural factors
  - poverty
  - poor pre-post natal care
  - exposure to environmental toxins
  - teenage pregnancy (premature, LBW)

Case 6: Boy with MR

- Genetic Conditions

1. Down's- trisomy 21, nondisjunction, translocation (21 and 15 fuse); 1:700 births
2. Fragile X- mutation in X at fragile site; +communiction and social skills, 1:1000
3. Prader- Willi- deletion in ch15, compulsive eating, obese, ODD; 1;10,000

Questions?